# SOUTH CAROLINA HEALTH INSURANCE POOL (SCHIP) HIGH DEDUCTIBLE HEALTH PLAN

# **POLICY FORM NO. 12261M (4/05)**

## **OUTLINE OF COVERAGE**

## **Read Your Policy Carefully**

This Outline of Coverage provides a very brief description of the important features of the policy issued by the South Carolina Health Insurance Pool (SCHIP). This is not the insurance contract and only the actual policy provisions will control your policy. The policy itself sets forth in detail the rights and obligations of you and the South Carolina Health Insurance Pool.

# COMPREHENSIVE MAJOR MEDICAL EXPENSE COVERAGE

The policy provides, to persons insured, coverage for major Hospital, medical and surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily Hospital room and board, miscellaneous Hospital services, surgical services, anesthesia services, in-Hospital services and out-of-Hospital care, subject to any Deductibles or other limitations set forth in the policy.

#### **IMPORTANT**

Here is one of the most important things you need to remember about this coverage:

You will receive maximum benefits under this policy if you get approval from the Administrator for inpatient Hospital admissions, Medically Necessary cosmetic reconstructive surgery, Home Health Care, Hospice Care, human organ and/or tissue transplants, Skilled Nursing Facility admissions and certain outpatient services. The amount payable under this policy for these services may decrease if you don't get approval. The *General Information* section of the policy tells you how to get approval from the Administrator for these services.

#### **ELIGIBILITY**

This policy provides individual coverage only. Each member of a family can buy his or her own individual coverage if he or she meets the eligibility requirements.

#### I. Residency Eligibility:

Both the applicant and the Responsible Party (if applicant is under age 18 or legally incapacitated) must have been a "Resident" of South Carolina for at least 30 days. This requirement is waived for a Federally Defined Eligible Individual or a TAA Eligible Individual. However, proof of residency will be required within 30 days after acceptance. The residency of the Responsible Party fulfills the residency requirement for an infant under the age of 30 days. The applicant and the Responsible Party must be Residents at the time of application and remain Residents continuously in order to continue coverage. The Administrator requires documentation of residency at the time of application. While the policy is in force, the Administrator will periodically verify residency.

# **Applicant Proof of Residency**

The applicant must include with the application a copy of one of the following documents showing residency for at least 30 days prior to the date of application: rent receipts, mortgage payment receipts, property tax receipts, utility bills or South Carolina driver license. The Administrator may request other documentation.

# Proof of Residency for an applicant under Guardianship:

#### **Responsible Party**

If an applicant is under age 18 or legally incapacitated, the Responsible Party must include with the application one of the following documents showing residency for at least 30 days prior to the date of application: rent receipts, mortgage payment receipts, property tax receipts, utility bills or South Carolina driver license. The Administrator may request other documentation.

# Applicant under age 18

For applicants under the age of 18 who are enrolled in school or daycare, the application must include a notarized statement, furnished by the Parent or Legal Guardian and executed by the school or daycare, which reflects the name of the facility in which the child is enrolled, its address and telephone number and the period of time enrolled. If the applicant isn't enrolled in school or daycare, the application must include documentation or evidence of residency as requested by the Administrator.

# Applicant who is legally incapacitated

For applicants who are legally incapacitated, the application must include any documentation or evidence of residency available and/or documentation requested by the Administrator.

NOTE: To remain eligible for SCHIP coverage, the Policyholder must reside continuously within the State of South Carolina for at least six months of each calendar year. If the Policyholder is under the age of 18 or legally incapacitated, the Responsible Party must also reside continuously within the State of South Carolina for at least the same six months of each calendar year.

## II. Medical/Rate Eligibility:

You must provide evidence of any of the following notifications by an insurer on an application for Health Insurance with benefits similar to those offered by SCHIP:

- a. A refusal to issue the insurance for health reasons.
- b. A refusal to issue the insurance except with a reduction or exclusion of coverage for a pre-existing health condition for a period exceeding 12 months, unless the Board determines that you: a) voluntarily terminated previous insurance; or b) did not seek any Health Insurance Coverage until after the health condition developed for which benefits would be reduced or excluded.
- c. A refusal to issue the insurance coverage comparable to that provided by SCHIP except at a rate exceeding 150% of the SCHIP rate.
- d. Received notice that the current rate for comparable Health Insurance is greater than 150% of the SCHIP rate or will be increasing to an amount greater than 150% of the SCHIP rate.

You are not eligible for coverage by SCHIP or for continuance of coverage by SCHIP if you meet any of the following criteria:

- a. You have Health Insurance Coverage similar to that offered by SCHIP from an insurer or any other source unless your premium is greater than 150% of the SCHIP premium.
- b. You are eligible for Health Insurance similar to that offered by SCHIP from an insurer or any other source <u>unless rule b or c above applies</u> or unless you are a Federally Defined Eligible Individual or a Qualified TAA Eligible Individual.
- c. You are eligible or become eligible for healthcare benefits under Medicare.
- d. You previously had coverage by SCHIP that you terminated and less than 12 months have passed since coverage ended (except if you are a Federally Defined Eligible Individual). However, if coverage ended because you were no longer eligible and you now are eligible you can apply for SCHIP coverage. If this is true, the pre-existing conditions limitations must be satisfied based on your new effective date.
- e. You have reached the maximum payout for an individual by SCHIP of \$1,000,000. However, if you have been covered by SCHIP in the past and a lapse of coverage has occurred, the lifetime maximum will be an accumulation and will include all prior benefits paid by SCHIP.
- f. You are an inmate of a public institution (except if you are a Federally Defined Eligible Individual).
- g. You are eligible for public programs that offer comparable Health Insurance Coverage.
- h. You, and/or the Responsible Party if applicable, don't maintain continuous residency within the State of South Carolina for at least six months of each calendar year. Failure to respond to an inquiry about your residency by the Administrator will result in the presumption of non-residency and termination of this policy.
- i. SCHIP finds that your premium, Deductible or Coinsurance amount is paid or reimbursed by a healthcare provider, health agency, health entity, public or private institution or any other person or entity which doesn't have an insurable interest in the applicant or the Policyholder. This doesn't apply to premiums submitted on your behalf if you are a Qualified TAA Eligible Individual.

## III. Federally Defined Eligible Individual or Qualified TAA Eligible Individual Eligibility:

The Residency and Medical/Rate Eligibility requirements are waived for a Federally Defined Eligible Individual or a person eligible under the Trade Adjustment Assistance Act (Qualified TAA Eligible Individual); however, proof of residency will be required within 30 days after acceptance.

## **EFFECTIVE DATES**

Your policy becomes effective as follows:

- 1. If your Health Insurance Coverage is terminated involuntarily for any reason other than non-payment of premium and you meet the eligibility requirements, the effective date is the date of termination of the prior coverage if you apply within 63 days of termination and pay premiums for the entire coverage period. Pre-existing conditions limitations are waived to the extent to which similar exclusions, if any, have been satisfied under the prior Health Insurance Coverage. The waiver does <u>not</u> apply to a person whose policy has been terminated or rescinded involuntarily because of a material misrepresentation.
- 2. If you are paying a premium greater than 150% of the SCHIP rate for comparable Health Insurance, the effective date for this coverage will be the date the existing coverage terminates if additional premiums for the existing coverage aren't paid. Any Waiting Period or pre-existing condition exclusion is waived to the extent to which similar exclusions, if any, were satisfied under the prior Health Insurance plan. Benefits payable under SCHIP are secondary to benefits payable by Extension of Liability from the previous plan. SCHIP will require a Surcharge to be paid.
- 3. If a newborn infant meets eligibility requirements and whose parent is covered by SCHIP applies within 63 days of the date of birth, the effective date of the newborn's policy is the date of birth.
- 4. If none of the above conditions apply, the effective date is the first billing date after the Administrator approves your application.

## PRE-EXISTING CONDITIONS LIMITATIONS

SCHIP won't cover any charges or expenses incurred during the first six months after your effective date under this policy for a condition if, during the six-month period immediately before the effective date of coverage:

- The condition would have caused a reasonable person to seek diagnosis, care or treatment; or
- Medical advice, care or treatment was recommended or received for that condition.

The Administrator will waive the pre-existing conditions limitations to the extent that similar exclusions, if any, were satisfied under previous health coverage if you are purchasing this policy because:

- 1. Your previous health coverage was involuntarily terminated for any reason other than non-payment of premium and you apply within 63 days of termination; or
- 2. At the time of application for SCHIP, the premium for your current comparable Health Insurance is greater than 150% of the SCHIP rate.

The pre-existing conditions limitations waiver doesn't apply to a person when the previous policy was terminated or rescinded involuntarily because of material misrepresentation.

Genetic Information won't be treated as a pre-existing condition in the absence of the diagnosis of a condition related to such information.

**Federally Defined Eligible Individual** – The pre-existing condition limitations will be waived for a Federally Defined Eligible Individual.

**Qualified TAA Eligible Individual** – The pre-existing condition limitations will be waived for a Qualified TAA Eligible Individual if the person had Creditable Coverage for a total period of three months as of the date when the person seeks to enroll in SCHIP, not counting any period prior to a 63-day break in coverage.

## **SUMMARY OF BENEFITS**

Deductible for the Policyholder each Benefit Period

Percentage of Covered Expenses payable per Benefit Period

\$1,500 - the Deductible applies to all covered services.

80% of the Allowable Charge after the Deductible has been met, for services received from Network Providers until the Out-of-pocket Expense has been met.

60% of the Allowable Charge after the Deductible has been met, for services received from Non-network Providers until the Out-of-pocket Expense has been met.

# Percentage of Covered Expenses payable per Benefit Period

After the Out-of-pocket Expense has been met, the policy will pay 100% of the Allowable Charge at Network and Non-network Providers (except for the following when the required prior approvals aren't obtained: inpatient Hospital admissions, Medically Necessary cosmetic reconstructive surgery, Home Health Care, Hospice Care, human organ and/or tissue transplants, Skilled Nursing Facility admissions and certain outpatient services).

## **Outpatient Review**

50% of the Allowable Charges are paid for Medically Necessary Home Health Care services, Hospice Care or any of the following outpatient procedures or supplies: chemotherapy or radiation therapy (first treatment only), hysterectomy, septoplasty, sclerotherapy or Durable Medical Equipment (DME) when the cost is \$100 or more when the Outpatient Review approval isn't obtained.

If the services aren't Medically Necessary, no benefits are paid even if you call for approval.

\$5,000 in Network and \$10,000 out-of-Network

# Out-of-pocket Expense per Benefit Period –

The Deductible and Coinsurance amounts apply toward your Out-of-pocket Expense.

#### **Benefit Period**

Maximum amount payable in a lifetime for the Policyholder

Calendar Year. The first Benefit Period begins on the effective date and ends on December 31. If the effective date of coverage is after January 1, the first Benefit Period will be less than twelve months. All subsequent Benefit Periods are on a calendar year.

\$1,000,000 including \$10,000 for combined inpatient and outpatient Psychiatric Care and the Transplant Lifetime Maximums.

Transplant Lifetime Maximums are the maximum amounts of benefits provided in a lifetime for each of the following transplants (preapproval is required). For transplants not listed, the Administrator will determine the Transplant Lifetime Maximum on an individual basis.

Kidney (single/double)	\$60,000
Pancreas and Kidney	\$150,000
Heart	\$120,000
Lung (single/double)	\$150,000
Liver	\$200,000
Heart and (single/double) Lung	\$200,000
Pancreas	\$80,000
Bone Marrow	\$200,000

# Daily Hospital room and board

Semi-private room or special care unit (such as burn, heart or intensive care).

## Other covered Hospital expenses

Miscellaneous inpatient Hospital expenses; outpatient surgery; treatment of accidents; outpatient diagnostic X-ray and lab charges; chemotherapy; inhalation therapy; physical therapy; radiation therapy.

#### **Inpatient Psychiatric Care**

50% of the Allowable Charge for covered inpatient expenses after the Deductible up to a maximum of 14 days each Benefit Period.

## **Physicians**

Surgery; administration of anesthesia; daily Hospital medical care; outpatient services; treatment of accidents; home and office visits not part of routine physical exams.

#### **Outpatient Psychiatric Care**

50% of the Allowable Charge up to \$40 per day, for up to 20 days per Benefit Period.

**Home Health Care** (Pre-approval required)

**Physical Therapy** 

**Other Covered Expenses** 

**Routine Benefits** 

Up to 40 days each Benefit Period if prescribed by a Physician.

Services of a licensed physical therapist when not inpatient (limited to 20 visits per Benefit Period).

Prescription drugs, Hospice Care and Durable Medical Equipment (preapproval required); oxygen and equipment for its use; prosthetic appliances; medical supplies; insulin; ambulance service; blood and blood plasma.

**OB-GYN** (obstetrical-gynecological) examination – For any female Policyholder, limited to two examinations annually.

**Pap smear screening** – Limited to one per female Policyholder per Benefit Period, or more often if recommended by a medical doctor.

A pap smear is an examination of cervical cells for the purpose of detecting cancer.

**Prostate exams, screening and lab work** – When performed according to the most recently published American Cancer Society (ACS) guidelines.

The most recently published ACS guidelines, dated July 1, 1998, recommend that both Prostate-Specific Antigen (PSA) and Digital Rectal Examination (DRE) should be offered annually to men age 50 and over who have at least a 10-year life expectancy, and to younger men who are at high risk.

Men who choose to undergo screening should begin at age 50. However, men in high-risk groups, such as those with a strong familial predisposition (e.g., two or more affected first-degree relatives) or African Americans may begin at age 45. The ACS guidelines are subject to change.

**Mammography** – For any female Policyholder according to the most recently published American Cancer Society (ACS) guidelines.

The most recently published ACS guidelines, dated July 1, 1998, recommend an annual mammography for women age 40 and over. The ACS guidelines are subject to change.

For a complete Summary of Benefits please refer to the policy.

## SERVICES AND SUPPLIES NOT COVERED

Some services and supplies you may get won't be covered under this policy. Benefits aren't provided for the following:

- 1. Room and board charges in any Hospital or Skilled Nursing Facility when the required approval isn't obtained as stated in this policy.
- 2. When you don't get the required preapproval on certain outpatient procedures, Home Health Care services, Hospice Care and DME, benefits will be reduced as shown in the *Summary of Benefits*.
- 3. Services, supplies or items that aren't Medically Necessary or not specifically listed as a covered benefit in the policy.
- 4. Services, supplies or treatment you received before you had coverage under this policy or that you receive after you are no longer insured under this policy, except for coverage, if any, provided in the "Termination Provision".
- 5. Care provided by the Department of Veterans Affairs (VA) for service-related disabilities.
- 6. Services or supplies not charged to you; or for which you aren't legally obligated to pay.
- 7. Inpatient admission for the sole purpose of receiving physical therapy.
- 8. Benefits for inpatient diagnostic services will be reduced to outpatient services when the services could have been done safely as an outpatient.

- 9. Any amount for Covered Expenses paid or payable through any other Health Insurance or health coverage.
- 10. All hospital or medical expense benefits paid or payable under workers' compensation (a settled workers' compensation claim is considered paid under workers' compensation), automobile medical payment or liability insurance whether provided on the basis of fault or nonfault.
- 11. All hospital or medical expense benefits paid or payable under or provided according to any state or federal law or program.
- 12. Services and supplies related to human organ and/or tissue transplants when preapproval from the Administrator isn't obtained and/or services and supplies aren't obtained from a provider the Administrator designates.
- 13. Human organ and/or tissue transplant procedures not specifically listed in this policy.
- 14. Surgical or medical care related to animal organ transplants, animal tissue transplants, artificial organ transplants or mechanical organ transplants.
- 15. Investigational or Experimental Services including, but not limited to, the following:
  - Uses of allogenic or syngeneic bone marrow transplants or other forms of stem cell rescue (with or without high doses of chemotherapy or radiation) in cases in which less than four of the six complex antigens match; cases in which mixed leukocyte culture is reactive; and Acquired Immunodeficiency and Human Immunodeficiency Virus infection;
  - Adrenal tissue to brain transplants;
  - Islet cell transplants;
  - Dorsal Rhizotomy in the treatment of spasticity;
  - Procedures that involve the transplantation of fetal tissues into a living recipient.
- 16. Medical care by a Physician other than the attending Physician during a Hospital admission unless a medical specialist is needed for a condition the attending Physician couldn't treat.
- 17. Routine physical exams, hearing exams, eye exams (including eye refractions), Hospital nursery charges and the first medical exam of a newborn well baby, well baby care and immunizations.
- 18. Services and supplies related to cosmetic surgery. This means any plastic or reconstructive surgery done mainly to improve the appearance of any body part, and from which no improvement in physiologic function is reasonably expected, unless performed either to correct functional disorder or as a result of an injury. Cosmetic surgery excluded includes, but isn't limited to:
  - Surgery for sagging or extra skin;
  - Any augmentation or reduction procedures;
  - Rhinoplasty and associated surgery; and
  - Any procedures using an implant that doesn't alter physiologic function or isn't incidental to a surgical procedure.
- 19. Custodial or intermediate care. This is care meant simply to help people who cannot take care of themselves.
- 20. Acupuncture.
- 21. Treatment of obesity or weight reduction, including any surgical procedures specifically designed to treat obesity and any complications arising from such treatment, other than gastric bypass and gastric stapling when Medically Necessary for the treatment of morbid obesity.
- 22. Hospital charges for dental treatment and any related services and complications.
- 23. Physician services directly related to the care, filling, removal or replacement of teeth, the treatment of injuries to the teeth if the injury occurs through the natural act of chewing or disease of the teeth, gums or structures directly supporting or attached to the teeth. This includes but isn't limited to: apicoectomy (dental root resection), root canal treatment, the excision or extraction of impacted teeth, alveolectomy and treatment of gum disease.
- 24. Services or supplies related to dysfunctional conditions of the chewing muscles, malpositions or deformities of the jaw bone(s), orthognathic deformities or temporomandibular joint syndrome.
- 25. Treatment resulting from war or acts of war (whether declared or undeclared); while in the military service or its auxiliary units.
- 26. An illness you get or injury you receive from participating in a riot or uprising, while committing a crime, felony or misdemeanor or while engaged in an illegal occupation.

- 27. Educational, occupational, rehabilitative, recreational or speech therapy except as covered in the 14 days annual limit for rehabilitative care described under Covered Inpatient Hospital Expenses.
- 28. Any type of rehabilitative care for alcohol, drug or other substance abuse.
- 29. Surgery to correct refractive errors, eyeglasses, contact lenses except after cataract surgery, hearing aids and examinations for their fitting.
- 30. Prescribed drugs you take home from a doctor's office, Hospital or Skilled Nursing Facility.
- 31. Prescribed drugs used for or related to birth control, weight control, obesity cosmetic purposes, smoking cessation, hair growth or fertility.
- 32. More than a 34 consecutive day supply for prescription drugs dispensed by prescription except for 100 unit doses for thyroid products, nitroglycerin, digitalis leaf and alkaloids.
- 33. Any type of service charge, including the administration or injection of a prescription drug.
- 34. Devices of any type (even though dispensed by prescription) including, but not limited to, contraceptive devices, therapeutic devices, artificial appliances or similar devices.
- 35. More than recommended daily dosage of any prescription drug as described in the current *Physician's Desk Reference* or prescription drug refills beyond one year from the original prescription date.
- 36. Over the counter supplies including, but not limited to: appliances, bandages, devices, sundries, non-prescription drugs, infant formula and food supplements, even if a Physician prescribes it
- 37. Private duty nursing services in a Hospital or Skilled Nursing Facility by licensed practical nurses (LPNs), registered nurses (RNs), sitters or companions.
- 38. Services or care used to detect and correct by manual or mechanical means, structural imbalance, distortion or subluxation in your body for the purpose of removing nerve interference and its effects when this interference is the result of or related to distortion, misalignment or subluxation of or in the spinal column.
- 39. Any treatment resulting from the Policyholder being intoxicated or under the influence of any narcotic or drug unless prescribed by a Physician.
- 40. Anesthesiology by the doctor who performs the patient's surgery or who delivers a baby.
- 41. Any expense or charge for sex change or any treatment related to sexual dysfunction.
- 42. Any expense or charge for the promotion of fertility including (but not limited to):
  - a. fertility tests;
  - b. reversal of surgical sterilization; and
  - c. any attempts to cause pregnancy by hormone therapy, artificial insemination, in vitro fertilization and embryo transfer or any similar treatment or method.
- 43. Care of bunions unless corrected by a surgical procedure; care of corns, calluses, nails of the feet, flat feet, fallen arches, chronic foot strain or symptomatic complaints related to the feet.
- 44. Any services provided by a relative. A relative means the spouse, parent, grandparent, brother, sister, child or in-law.
- 45. Any intentionally self-inflicted injury or illness, whether sane or insane.
- 46. Services or supplies not performed or prescribed by a Physician.
- 47. Travel, luxury or convenience items, even if a Physician recommends it.
- 48. Advice or consultation given by or through any form of telecommunication such as a telephone consultation or a virtual office visit via the Internet.
- 49. Charges for completion of any insurance form or as the result of a missed appointment.
- 50. Any service or treatment for complications resulting from any non-covered procedures.

## RENEWABILITY

SCHIP may non-renew this policy for the reasons stated below.

If the Administrator finds that you don't meet any of the eligibility requirements described in this policy, it will decline to renew your policy the next time your premium is due. SCHIP may decline to renew your policy if Act 127 of 1989 is amended or repealed and SCHIP is instructed not to renew existing policies. SCHIP may decline to renew your policy if a new policy form replaces this policy form. If SCHIP replaces the policy form, SCHIP may offer to replace everyone's policy with the new policy form.

SCHIP won't decline to renew your policy simply because of a change in your physical or mental health except as specified in the *Eligibility* section.

You will receive 31 days written notice if SCHIP doesn't renew your policy.

#### RENEWAL AND TERMINATION

Your policy will be renewed for one month each time you pay the required premium by the due date or within the 31-day grace period until the earliest of the following dates:

- 1. The next premium due date following the date you are no longer eligible according to the rules under the *Eligibility* section;
- 2. The date you request the policy to end;
- 3. The date South Carolina statutes require cancellation of the policy;
- 4. The date of any fraudulent act as determined by the Board. In the case of material misrepresentation in application, the policy will be rescinded as of the effective date of coverage;
- 5. The date that the Board determines that your premium, Deductible or Coinsurance amount is being paid or reimbursed by a healthcare provider, health agency, health entity, public or private institution, or any other person or entity which doesn't have an insurable interest in the applicant or Policyholder.

#### **PREMIUMS**

The included premium rate sheet shows the current premium charged for each attained age group for this policy. SCHIP has the right to change this table of premiums on a class basis. If this table of premiums changes, the Administrator will tell you at least 31 days in advance of the date that the change affects you.

Note that your premium also changes as you enter an older attained age group.

You pay premiums each month. If premiums change, you pay the new rates the next time your premium is due.

## EXTENSION OF BENEFITS AFTER TERMINATION OF COVERAGE

Extension of Benefits doesn't apply if SCHIP does not renew your policy because you fail to meet the eligibility requirements, or because South Carolina statutes require cancellation of your policy or because the Board determines that you defrauded SCHIP. If SCHIP does not renew the policy for any other reason, and you are in the Hospital or Continuously Disabled when the coverage under the policy ends, benefits will be paid while you remain Continuously Disabled for the same or a related cause. Payments will only be made for services related to the disabling condition and will continue until the earlier of:

- 1. The date of recovery from Continuous Disability.
- 2. You receive benefits for Covered Expenses for up to 365 days from the date the coverage is terminated.
- 3. You use all benefits available under the policy.